COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

Meeting Summary
12-21-2015
COPIC, Mile High Room

Commissioners present: Bill Lindsay (chair), Cindy Sovine-Miller (vice chair), John Bartholomew, Jeffrey Cain, Rebecca Cordes, Jeff D'Argonne, Steve ErkenBrack (phone), Ira Gorman, Linda Gorman, Marcy Morrison (phone), Chris Tholen, Jay Want, Larry Wolk
Staff: Lorez Meinhold and Cally King (Keystone)

I) Approval of the Minutes

A) Approval of Minutes from December 14th moved by Rebecca, and seconded by Jeff.

B) Minutes from the December 14th meeting were approved without changes or opposition.

II) Presentations on Transparency tools:

A) **Health Care Blue Book, Graham Chalfant**

1) Graham Chalfant provided a presentation on the services offered by Health Care Blue Book that help with determining pricing and quality of health related services. The presentation can be found on the Commission website.

2) Questions and Discussion:

(a) Between pricing and quality, how does Health Care Blue Book differentiate? How often are the costs updated and what is the accuracy of the data?

(i) The quality data is updated annually. Pricing data is updated quarterly; use claims data to see who qualifies for awards. There are a lot of outpatient procedures that are all about price quality and are hard to determine quality of care; inpatient procedures are about cost and quality of care.

(b) Let's say someone picks a physician/ provider and that physician/provider uses a certain facility; how do the various factors from that facility get tied into Health Care Blue Book's program?

(i) When you look at price variances, most of those differences come from facility charges. Big variance comes in where procedures are done. When someone picks the specialist first before the facility, it does get trickier because you may not be able to use the tool to find a lower cost facility without changing providers.

(c) It is implied that outpatient procedures are driven by price and convenience, but I'm not sure if that is entirely true. Technology plays a large role in patient choice and there is great variation in availability of technology at different facilities and along with that there is a cost difference.

(i) Two pieces to this - when deciding on one facility over another, the patient needs to talk to their physician to see if there is a certain machine or technology they need to use because the latest technology may not be necessary for treatment. There is also not a correlation between high cost facilities and what type of technology they use. What has been found more consistently is that the bigger the hospital system, the higher their costs; there is no correlation that they are high cost because they are using the most advanced machines.

B) **Castlight, Braxton Hogan**

1) Braxton Hogan provided a presentation on the services offered by Castlight to help determine price and quality of health related services. The presentation can be found on the Commission website.
2) Questions and Discussion:
   (a) With regards to the last slide showing employer access to information, I have worked on legislation for access to similar information with the disability community. Many times this type of legislation fails. What feedback have you heard from employers on this information?
      (i) All the information is HIPAA compliant and provided on an aggregated level.
   (b) What percentage of population access Castlight's data and use the search tool?
      (i) We've seen engagement rates as high as 85 percent, typical usage is 50-60 percent. Castlight measures success as engagement (return usage) and not registration.
   (c) On the comparison of hospitals, where does Castlight get data on the cost component?
      (i) Cost data are carrier data that comes from claims.
   (d) When you look at cost and quality data, do you have physician specific data?
      (i) We have Castlight user reviews that we share with all our members. We also look at procedure volume for surgeons to gauge their experience – i.e., you would probably want a surgeon who has performed an operation many times before opposed to one who has only performed the operation a limited amount of times.

III) Presentation from Colorado Association of Family Physicians on Rhode Island, Ryan Biehle

A) Ryan Biehle provided a presentation on a Rhode Island initiative to increase the state's share of health care spending on primary care. The presentation can be found on the Commission website.

B) Questions and discussion:
   1) How much of this benefit was due to payment reform or delivery reform?
      (a) The valuation done by the researcher goes more into those aspects. They don't parse out the percentages, but see them as standards in conjunction. As primary care spending was increasing, the share going towards payments was also increasing. The anecdotal evidence says that increased primary care dollars has helped them transform.
   2) Important to note that an experiment like this takes time, it is an investment in culture and systems changes. It is not a short term, quick response.
   3) Was there any attempt to compare this with trends in other states? Overall Spending went down in all states during the recession. How many patients were in gatekeeper systems where they couldn't access primary care without permission or referral?
      (a) There has not been a direct comparison to other states; nationally medical expenditures have not gone down. Unsure what number went into a gatekeeper model, a number did have strict managed care that one may have expected in the 1990s. Primary care was 10 to 16 percent of healthcare expenditures and that is how they picked their percentage.
   4) How did this program come to be? Was it a legislative initiative or a collaborative process?
      (a) The genesis was early in 2008 through legislation. The rest was done through the state's division of insurance and a collaboration of payers and providers in the state. A number of payers and providers have seen this as a very positive program in implementing payment and delivery reform transformation.
   5) Could you check on the gatekeeper piece and see if it is easily obtainable? When we go back to look at health care spending in United States overall, spending dropped in the 1990s. Led to question if this was depriving people access or if there was more efficient, appropriate care. In many states, they are not using a primary care gatekeeper in a traditional sense. Would be good to know how product was structured to help inform this discussion.

IV) Public Comment

A) George Swan, Retired Hospital Administrator: I've been on the Castlight and Health Care Blue Book websites and have recommended to them to use pivot tables and aggregators for data. I would make the point that one of the sources is the HCAP results, that pivot table is available to the Commission on your website. The pivot table shows variations hospital by hospital. Another pivot table shows top hospitals by DRGs. We need to mention the CIVIHC APCD information. I also wanted to make a point that I'm a Kaiser Senior Advantage patient; when I got my first chemo treatment it was $260,000 for first stay. Kaiser was contractually agreed to 97 percent. I have maxed out my deductible. More importantly is notion, if you go to YouTube and take the time to look at power pivot, which is available to anyone with excel, it can handle billions of transactions. You'll appreciate none of these people use this, even though they could produce very powerful pivot tables to the public. All these things could easily be done at the public level. The last presentation you just saw on Rhode Island, there's also a pivot table available on national health expenditures. In addition there is a pivot table on county health rankings; Rhode Island is running at 97 percent index. These comparisons across states with different indicators is essential. This information should be used.

B) Amy Downs, CHI: The last presentation was intriguing, I've never seen health care spending going down. For context, I looked into what was going on in Rhode Island. The Insurance Commission there says what happened was that this initiative applied to those in fully insured products. A lot of people went into ERISA plans during this time. It's not accurate to look at entire spending because so many people went out of those products. CHI can get those numbers to you.

V) Presentation on Palliative Care, Dr. Angelo Volandes, Harvard Medical School

A) Dr. Angelo Volandes provided a presentation on palliative care and providing patients and families a better understanding of the health care system and end of life decisions. The presentation can be found on the Commission website.

B) Questions and discussion:

1) In Hawaii, this was something the hospitals decided made good policy and was done voluntarily opposed as through legislation – is that correct?
   (a) Complicated, most physicians would say it's the right thing to do but in health care you need carrots and sticks. In Hawaii we said we would provide them with videos and iPads (carrot); the stick was to say that we are going to give you a bonus at end of year if you are able to show us that you had conversations, showed videos and had documentation. Found that cost savings of showing the video were thousands of dollars adverted from unwanted care. A stick is take away money not give a bonus?>? Confusing unless the stick was not to get the bonus that was promised.
2) It seems like people made decision after watching video what happens at action phase. When it really comes down to it, sometimes decisions change when survival mode kicks in.
   (a) We do follow people over time to see what happens. Do people change their mind or stick to initial decision? When people see the video they are more likely to make a decision early on and stick to it.
3) How many different videos have you produced?
   (a) We have over 100 videos, and anticipate about 150 by middle of next year. The videos are in the 15 most common languages in America. Have started making videos for healthy people for proactive, advanced care planning. We are also making videos for different procedures to help people understand the care they might receive; videos for care partners and care givers.
4) Intrigued by the pie graph, especially by the difference between loved ones vs. patient once they see the video. Can you opine why you see this difference?

(a) Patients and families are simply not prepared to make these decisions. The general idea is to say, "Save my loved one." Once families see what the care looks like, they have a better understanding of what they are putting their loved ones through to save them.

5) There is a discontinuity as folks move through different places in the health care system and there needs to be more continuity of care. The other part is that having a box to check at the hospital may not go the way the patient is able to have the decision they want because it doesn't allow time for this kind of conversation.
6) Have you had media experts look at these videos to make sure they are balanced and don't bias people's emotions? The video showed comfort care in better light than the other options.
   (a) Videos are vetted by an expert panel known for end of life care. We don't just use doctors, also use nurses, social workers, chaplains, patients with terminal illnesses and their loved ones. The videos help provide standardization to the process, whereas doctors provide the same information in a variety of different ways depending on their own personal tastes on how they talk to patients.
   (b) The reality of a resuscitation process is actually much more brutal and violent than the video portrays; from a practitioner's perspective it provides a balanced perspective and a very sterilized view of what it actually looks like.
7) The true value in this is giving a patient more complete information and helps prompt better questions of the provider. This could be a good thing for health care to help implement in Colorado. It crosses many aspects the Commission is supposed to look at. I would ask that the Commissioners think about this and consider as a recommendation to discuss.
   (a) How does this work in a state without a dominant insurer and instead has many insurers; what would your recommendation be to implement something like this in an environment like Colorado?
      (i) Immediately in Hawaii, we got all six insurers on the islands to meet. One CEO told me he hates the other five competitors but was willing to work together because everything they are doing in end of life care is wrong. Called it "coopetition." It is important to address end of life costs. It shouldn't be hard to bring everyone to the table because they realize it will only work if they all work together.
      (ii) Caveat to add is that if insurers are driving the process, everyone will say this is about cost. If we could look at coalition that includes hospitals, medical society and insurers together then you'd have a more holistic approach that is less subjective to criticism.
   (b) Would like to emphasize idea that when we are to move forward and look at cooperating, the one group is many consumers of medical care that would feel very strongly in favor of this approach and offer view that this is not done by the medical groups in the state.
   (c) From the Medicaid office perspective, with any payer this is a great conversation to have but is a touchy subject. There have been many end of life care bills that have died in past legislative sessions. I couldn't comment on the position of Medicaid on the policy at this time.
   (d) This is a transparency issue to provide more information to consumers to make better decisions.
   (e) Would this be a standard imposed on practitioners or hospitals? Is this an insurance requirement that insurers would be required to do? Where does the obligation lie? What is access to suite of videos and who would have access to those videos? In theory, it is great, but devil would be in the details and would like to see what direction this would go.

VI) Public Comment:

A) George Swan: How many of you have direct experience of a relative using hospice? I was a believer of hospice before and when my mother and sister both had terminal cancer and used hospice care; I was sold on it – they did a tremendous job. There is a 2x2 matrix for high tech and high touch for patients with terminal conditions and measured patients who died in ICU opposed to those in hospital that were not in ICU. We had to introduce extra field in death certificates to pull this kind of data. At the CDC level they are trying to introduce more information from death certificates and that is something that could be done on the state level to get concurrent information about this kind of data.

VII) Updates and Business, Bill Lindsay/Commissioners

A) Elections
   1) Elections will be postponed to January since bylaws require all Commissioners be in attendance. If we cannot get full attendance, may look into paper ballot and see if this is a possibility.

B) Planning Committee, Bill Lindsay
   1) Working on schedule for remaining months to have topics organized and synchronized. The February meeting will focus on social determinants in health.
   2) Will be revisiting schedule for statewide meetings with Commissioners
   3) Next report to General Assembly due in July; could be last report depending on what happens from a budget standpoint.
      (a) The Commission will need to think about our recommendations for that report.
      (b) Think about possible legislation, but realize there are things going on in the market that make it so legislation is not necessary in every area.
   4) There are some legislators who want to run bills in the upcoming session to make requests of the Commission on our opinions on different topics. We need to think about this from a strategic and operational standpoint. We don't want to get caught-up in a partisan debate if we don't have to. We also have a very busy calendar with a lot of issues to talk about and do we want to run the risk of going down some real rabbit holes? Some of the requests will be important to address and we need to be careful about the fights we want to get involved with and how we do this from a decorum standpoint. Need to be thoughtful in our interactions with legislators and also notify Lorez and Bill of any questions from legislators that may come to Commissioners.
      (a) Have heard concern about amendment 69 and where it might go and feeling legislature needs to show they are doing something and the only solution is not amendment 69; have not heard what those other suggestions might be.
      (b) Contacted about the Physical Therapy cost sharing transparency bill and request to weigh in on that as a Commission
      (c) Pharmaceutical transparency, but hard to articulate what exactly they want to do.
   5) The Commission will revisit the Milliman report and must do this during the time the General Assembly is meeting – likely in January or February.

C) Budget Update, Chris Tholen
   1) The budget is available on the Commission website
   2) Between $400,000 of original appropriation, $75,000 from foundations and a little interest collected – at the end of FY2016 the Commission will have approximately $82,000. The Commission has enough funding to go through September 2016 and will need to find additional funding to go beyond that. We have not used much of our legal funds, but if we do statewide meetings this will offset those savings.
   3) Questions and discussion:
      (a) Is there money set aside for the statewide meetings?

(i) Yes, they were just delayed to a later time. However, we do not have money in the budget for refreshments and things like that at the statewide meetings.

(b) Thanks and recognition to Chris Tholen for his time on putting together the budget.

D) Next meeting January 11th at 12:30pm

1) Commission moving back to monthly meetings, the second Monday of the month from 12:30 – 3:30 or 4:00pm depending on the agenda topic. Lorez will send out calendar invite to Commissioners.

VIII) Public Comment:

A) George Swan: Would like to introduce subject related to cost issues, I'm a bit surprised how difficult it is to get access to Medicare cost reports of hospitals in Colorado. In California you can access the last four years and they maintain a pivot table over the past five years. This is required reading if you're looking at hospitals' annual cost reports, financials and utilizations. I haven't heard this raised and think it should be brought forward to have more access to Medicare cost reports.